CABINET FOR HEALTH AND FAMILY SERVICES

Office of Health Policy

(Amendment)

900 KAR 7:030. Data reporting by health care providers.

RELATES TO: KRS Chapter 13B, 216.2920-216.2929

STATUTORY AUTHORITY: KRS 216.2923(3), 216.2925

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216.2925 requires that the Cabinet for Health and Family Services promulgate administrative regulations requiring specified health care providers to provide the cabinet with data on cost, quality, and outcomes of health care services provided in the Commonwealth. KRS 216.2923(3) authorizes the cabinet to promulgate administrative regulations to impose fines for failure to report required data. This administrative regulation establishes the required data elements, forms, and timetables for submission of data to the cabinet and fines for noncompliance.

Section 1. Definitions. (1) "Agent" means any entity with which the cabinet may contract to carry out its statutory mandates, and which it may designate to act on behalf of the cabinet to collect, edit, or analyze data from providers.

(2) "Ambulatory facility" is defined by KRS 216.2920(1).

(3) "Cabinet" is defined by KRS 216.2920(2).

(4) "Coding and transmission specifications", "Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals", or "Kentucky Data Coordinator's Manual for

Ambulatory Facilities" means the document containing the technical directives the cabinet issues concerning technical matters subject to frequent change, including codes and data for uniform provider entry into particular character positions and fields of the standard billing form and uniform provider formatting of fields and character positions for purposes of electronic data transmissions.

(5) "Hospital" is defined by KRS 216.2920(6).

(6) "Hospitalization" means the inpatient medical episode identified by a patient's admission date, length of stay, and discharge date, that is identified by a provider-assigned patient control number unique to that inpatient episode, except for:

(a) Inpatient services a hospital may provide in swing, nursing facility, skilled, intermediate or personal care beds; or

(b) Hospice care.

(7) "National Provider Identifier" or "NPI" means the unique identifier assigned by the Centers for Medicare and Medicaid Services to an individual or entity that provides health care services and supplies.

(8) "Outpatient services" means services performed on an outpatient basis in a hospital in accordance with Section 3(2) of this administrative regulation or services performed on an outpatient basis by an ambulatory facility in accordance with Section 4 of this administrative regulation.

(9) "Provider" means a hospital, ambulatory facility, clinic, or other entity of any nature providing hospitalizations, mammograms, or outpatient services as defined in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals or the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(10) "Record" means the documentation of a hospitalization or outpatient service in the format prescribed by the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals or the Kentucky Data Coordinator's Manual for Ambulatory Facilities as approved by the Statewide Data Advisory Committee on a computer readable electronic medium.

(11) "Standard Billing Form" means the uniform health insurance claim form pursuant to KRS 304.14-135, the Professional 837 (ASC X12N 837) format, the Institutional 837 (ASC X12N 837) format, or its successor as adopted by the Centers for Medicare and Medicaid Services, or the HCFA 1500 for use by hospitals and other providers in billing for hospitalizations and outpatient services.

Section 2. Medicare Provider-Based Entity. A licensed outpatient facility that is a Medicare provider-based entity of a hospital and reports under the hospital's provider number shall be separately identifiable through a facility-specific NPI.

Section 3. Data Collection for Hospitals. (1) Inpatient Hospitalization records. Hospitals shall document every hospitalization they provide on a Standard Billing Form and shall, from every record, copy and provide to the cabinet the data specified in Section 12 ~~[13]~~ of this administrative regulation.

(2) Outpatient services records.

(a) Hospitals shall document on a Standard Billing Form the outpatient services they provide and shall from every record, copy and provide to the cabinet the data specified in Section 12 ~~[13]~~ of this administrative regulation.

(b) Hospitals shall submit records that contain the required outpatient services procedure codes specified in the Kentucky Inpatient and Outpatient Data Coordinator's

Manual for Hospitals.

(3) Data collection on patients. Hospitals shall submit required data on every patient as provided in Section 12 [~~13~~] of this administrative regulation, regardless of the patient's billing or payment status.

Section 4. Data Collection for Ambulatory Facilities. (1) Outpatient Services Records.

(a) Ambulatory facilities shall document on a Standard Billing Form the outpatient services they provide and shall, for every record, copy and provide to the cabinet the data specified in Section 13 [~~14~~] of this administrative regulation.

(b) Ambulatory facilities shall submit records that contain the required outpatient services procedure codes specified in the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(2) Data collection on patients. Ambulatory facilities shall submit required data on every patient as provided in Section 13 [~~14~~] of this administrative regulation, regardless of the patient's billing or payment status.

Section 5. Data Finalization and Submission by Providers. (1) Submission of final data.

(a) Data shall be final for purposes of submission to the cabinet as soon as a record is sufficiently final that the provider could submit it to a payor for billing purposes, regardless of whether the record has actually been submitted to a payor.

(b) Finalized data shall not be withheld from submission to the cabinet on grounds that it remains subject to adjudication by a payor.

(c) Data on hospitalizations shall not be submitted to the cabinet before a patient is

discharged and before the record is sufficiently final that it could be used for billing.

(2) Data submission responsibility.

(a) If a patient is served by a mobile health service, specialized medical technology service, or another situation where one (1) provider provides services under contract or other arrangement with another provider, responsibility for providing the specified data to the cabinet shall reside with the provider that bills for the service or would do so if a service is unbilled.

(b) Charges for physician services provided within a hospital shall be reported to the cabinet.

1. Responsibility for reporting the physician charge data shall rest with the hospital if the physician is an employee of the hospital.

2. A physician charge contained within a record generated by a hospital shall be clearly identified in a separate field within the record so that the cabinet may ensure comparability when aggregating data with other hospital records that do not contain physician charges.

(3) Transmission of records.

(a) Records submitted to the cabinet by hospitals shall be uniformly completed and formatted according to coding and transmission specifications set forth by the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals.

(b) Records submitted to the cabinet by ambulatory facilities shall be uniformly completed and formatted according to coding and transmission specifications set forth by the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(c) All providers shall submit <u>data by electronic transmission as specified by the</u>

Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals and the Kentucky Data Coordinator's Manual for Ambulatory Facilities [~~records on computer-readable electronic media~~].

(d) Providers shall provide back-up security against accidental erasure or loss of the data until all incomplete or inaccurate records identified by the cabinet have been corrected and resubmitted.

(4) Verification and audit trail for electronic data submissions.

(a) Each provider shall maintain a date log of data submissions and the number of records contained in each submission, and shall make the log available for inspection upon request by the cabinet.

(b) The cabinet shall, within twenty-four (24) hours of submission, verify by electronic message to each provider the receipt of the provider's data transmissions and the number of records in each transmission.

(c) A provider shall immediately notify the cabinet of a discrepancy between the provider's date log and a verification notice.

Section 6. Data Submission Timetable for Providers. (1) Quarterly submissions. Providers shall submit data at least once for each calendar quarter. A quarterly submission shall:

(a) Contain data, which during that quarter became final as specified in Section 5(1) of this administrative regulation; and

(b) Be submitted to the cabinet not later than forty-five (45) days after the last day of the quarter.

1. If the 45th day falls on a weekend or holiday, the submission due date shall

be the next working day.

2. Calendar quarters shall be January 1 through March 31, April 1 through June 30, July 1 through September 30, and October 1 through December 31.

(2) Submissions more frequent than quarterly. Providers may submit data after records become final as specified in Section 5(1) of this administrative regulation and at a reasonable frequency convenient to a provider for accumulating and submitting batch data.

Section 7. Data Corrections for Providers [~~Hospitals~~]. (1) Editing. Data received by the cabinet shall, upon receipt, be edited to ensure completeness and validity of the data. Computer editing routines shall identify for correction every record in which the submitted contents of required fields are not consistent with the cabinet's coding and transmission specifications contained in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals and the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(2) Submission of [~~Time permitted for~~] corrections. The cabinet shall allow providers thirty (30) days in which to submit corrected copies of initially submitted data the cabinet identifies as incomplete or invalid as a result of edits.

(a) The thirty (30) days shall begin on the date of the cabinet's notice informing the provider that corrections are required.

(b) Providers shall submit to the cabinet corrected data by electronic transmission [~~or postmarked mailing~~] within thirty (30) days.

(c) Corrected data submitted to the cabinet shall be uniformly completed and formatted according to the cabinet's coding and transmission specifications contained in

the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals and the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(3) Percentage error rate.

(a) When editing data upon its initial submission, the cabinet shall identify and return to the provider for correction every record in which one (1) or more of the required data elements fails to pass the edit.

(b) When editing data that a provider has submitted, the cabinet shall check for an error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is greater.

~~[(d) For the first data submission, the cabinet shall not count as errors any data for patients admitted prior to thirty (30) days of the effective date of this administrative regulation.~~

Section 8. [~~Data Corrections for Ambulatory Facilities. (1) Editing. Data received by the cabinet shall, upon receipt, be edited to ensure completeness and validity of the data. Computer editing routines shall identify for correction every record in which the submitted contents of required fields are not consistent with the cabinet's coding and transmission specifications contained in the Kentucky Data Coordinator's Manual for Ambulatory Facilities.~~

~~(2) Time permitted for corrections. The cabinet shall allow providers thirty (30) days~~

~~in which to submit corrected copies of initially submitted data the cabinet identifies as incomplete or invalid as a result of edits.~~

~~(a) The thirty (30) days shall begin on the date of the cabinet's notice informing the provider that corrections are required.~~

~~(b) Providers shall submit corrected data by electronic transmission or postmarked mailing within the thirty (30) days.~~

~~(c) Corrected data submitted to the cabinet shall be uniformly completed and formatted according to the cabinet's coding and transmission specifications contained in the Kentucky Data Coordinator's Manual for Ambulatory Facilities.~~

~~(d) The cabinet shall grant a provider an extension of time to submit corrections, if the provider has formally informed the cabinet of significant problems in performing the corrections and has formally requested, in writing, an extension of time beyond the thirty (30) day limit.~~

~~(3) Percentage error rate.~~

~~(a) When editing data upon its initial submission, the cabinet shall identify and return to the provider for correction every record in which one (1) or more of the required data elements fails to pass the edit.~~

~~(b) When editing data that a provider has submitted, the cabinet shall verify an error rate per quarter of no more than one (1) percent of records or not more than (10) records, whichever is greater.~~

~~(c) The cabinet may return for further correction any submission of allegedly corrected data in which the provider fails to achieve a corrected error rate per quarter of no more than one (1) percent of records or not more than ten (10) records, whichever is~~

~~more.~~

~~Section 9.~~] Fines for Noncompliance for Providers. (1) A provider failing to meet quarterly submission guidelines as established in Sections 6 and [~~,~~] 7[~~, and 8~~] of this administrative regulation shall be assessed a fine of $500 per violation.

(2) The cabinet shall notify a noncompliant provider by certified mail, return receipt requested, of the documentation of the reporting deficiency and the assessment of the fine.

(3) A provider shall have thirty (30) days from the date of receipt of the notification letter to pay the fine which shall be made payable to the Kentucky State Treasurer and sent by certified mail to the Kentucky Cabinet for Health and Family Services, Office of Health Policy, 275 East Main Street 4 W-E, Frankfort, Kentucky 40621.

(4) Fines during a calendar year shall not exceed $1,500 per provider.

Section 9 [~~10~~]. Extension or Waiver of Data Submission Timelines. (1) Providers experiencing extenuating circumstances or hardships may request from the cabinet, in writing, a data submission extension or waiver.

(a) Providers shall request an extension or waiver from the Office of Health Policy on or before the last day of the data reporting period to receive an extension or waiver for that period.

(b) Extensions and waivers shall not exceed a continuous period of greater than six (6) months.

(2) The cabinet shall consider the following criteria in determining whether to grant an extension or waiver:

(a) Whether the request was made due to an event beyond the provider's control,

such as a natural disaster, catastrophic event, or theft of necessary equipment or information;

(b) The severity of the event prompting the request; and

(c) Whether the provider continues to gather and submit the information necessary for billing.

(3) A provider shall not apply for more than three (3) extensions or waivers during a calendar year.

Section 10[~~11~~]. Appeals for Providers. (1) A provider notified of its noncompliance and assessed a fine pursuant to Section 8 [~~9~~](1) of this administrative regulation shall have the right to appeal within thirty (30) days of the date of the notification letter.

(a) If the provider believes the action by the cabinet is unfair, without reason, or unwarranted, and the provider wishes to appeal, it shall appeal in writing to the Secretary of the Cabinet for Health and Family Services, 5th Floor, 275 East Main Street, Frankfort, Kentucky 40621.

(b) Appeals shall be filed in accordance with KRS Chapter 13B.

(2) Upon receipt of the appeal, the secretary or designee shall issue a notice of hearing no later than twenty (20) days before the date of the hearing. The notice of the hearing shall comply with KRS 13B.050. The secretary shall appoint a hearing officer to conduct the hearing in accordance with KRS Chapter 13B.

(3) The hearing officer shall issue a recommendation in accordance with KRS 13B.110. Upon receipt of the recommended order, following consideration of any exceptions filed pursuant to KRS 13B.110(4), the secretary shall enter a final decision pursuant to KRS 13B.120.

Section 11[~~12~~]. Working Contacts for Providers. (1) On or before the last day of the data reporting period [~~By January 1 of each calendar year~~], a provider shall report by electronic transmission [~~letter~~] to the cabinet the names and telephone numbers of a designated contact person and one (1) back-up person to facilitate technical follow-up in data reporting and submission.

(a) A provider's designated contact and back-up shall not be the chief executive officer unless no other person employed by the provider has the requisite technical expertise.

(b) The designated contact shall be the person responsible for review of the provider's data for accuracy prior to the publication by the cabinet.

(2) If the chief executive officer, designated contact person, or back-up person changes during the year, the name of the replacing person shall be reported immediately to the cabinet.

Section 12 [~~13~~]. Required Data Elements for Hospitals. (1) Hospitals shall ensure that each record submitted to the cabinet contains at least the data elements identified in this section and as provided on the Standard Billing Form.

(2) Asterisks identify elements that shall not be blank and shall contain data or a code as specified in the cabinet's coding and transmission specifications contained in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals.

(3) Additional data elements, as specified in the Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals, shall be required by the cabinet to facilitate proper collection and identification of data.

Required	DATA ELEMENT LABEL

Yes	*Provider Assigned Patient Control Number
Yes	*Provider Assigned Medical Record Number
Yes	*Type of Bill (inpatient, outpatient or other)
Yes	*Federal Tax Number or Employer Identification Number (EIN)
Yes	*Facility-specific NPI
Yes	*Statement Covers Period
Yes	*Patient City and Zip Code
Yes	*Patient Birth date
Yes	*Patient Sex
Yes	*Admission/Start of Care Date
Yes	Admission Hour
Yes	*Type of Admission
Yes	*Source of Admission
Yes	*Patient Status (at end of service or discharge)
No	Occurrence Codes & Dates
No	Value Codes and Amounts,

	including birth weight in grams
Yes	*Revenue Codes/Groups
Yes	*HCPCS/Rates/Hipps Rate Codes
No	Units of Service
Yes	*Total Charges by Revenue Code Category
Yes	*Payor Identification - Payor Name
Yes	*National Provider Identifier
Yes	*Diagnosis Version Qualifier - ICD version 9.0 or 10.0
Yes	*Principal Diagnosis Code
No	Principal Diagnosis Code present on admission identifier for non-Medicare claims
Yes	*Principal Diagnosis Code present on admission identifier for Medicare claims
Yes	*Secondary and Other Diagnosis Codes if present
No	Secondary and Other Diagnosis code present on

	admission identifier if present for non-Medicare claims
Yes	*Secondary and Other Diagnosis code present on admission identifier if present for Medicare claims
No	Inpatient Admitting Diagnosis or Outpatient reason for visit
Yes	*External Cause of Injury Code (E-code) if present
No	External Cause of Injury (E-code) present on admission identifier on non-Medicare claims if present
Yes	*External Cause of Injury (E-code) present on admission identifier on Medicare claims if present
Yes	*Principal Procedure Code & Date if present
Yes	*Secondary and Other Procedure Codes & Date if present

Yes	*Attending Physician NPI/QUAL/ID
No	Operating Clinician ID Number/NPI
No	Other Physician NPI/QUAL/ID
Yes	*Race
Yes	*Ethnicity
Yes	*Procedure Coding Method

Section 13 [14]. Required Data Elements for Ambulatory Facilities.(1) Ambulatory facilities shall ensure that each record submitted to the cabinet contains at least the data elements identified in this section and as provided on the Standard Billing Form.

(2) Asterisks identify elements that shall not be blank and shall contain data or a code as specified in the cabinet's coding and transmission specifications contained in the Kentucky Data Coordinator's Manual for Ambulatory Facilities.

(3) Additional data elements, as specified in the Kentucky Data Coordinator's Manual for Ambulatory Facilities, shall be required by the cabinet to facilitate proper collection and identification of data.

Required	DATA ELEMENT LABEL
Yes	*Patient Birth date
Yes	*Patient Sex
Yes	*Zip Code
Yes	*1st Individual Payer ID#
Yes	*Admission/Start of Care Date

Yes	*Type of Bill
Yes	*Principal Diagnosis Code
Yes	*Secondary and Other Diagnosis Codes if present
Yes	*Principal Procedure Code & Date
Yes	*Secondary and Other Procedure Codes & Date if present
Yes	*1st Units of Service
Yes	*1st Charge
No	Secondary and Other Units of Service and Charge
Yes	*Total Charges for the Case
Yes	*Attending Clinician NPI
Yes	*Provider Assigned Patient ID#
Yes	*1st Insurer Group #
No	2nd Insurer Group #
Yes	*Operating Clinician NPI
Yes	*Billing Facility-specific NPI
Yes	*Federal Tax Number or Employer Identification Number

	(EIN)
Yes	*Statement Covers Period
Yes	*Primary Payor Name
No	Secondary Payor Name
Yes	*Race
Yes	*Ethnicity
Yes	*HCPCS/Rates/Hipps Rate Codes

Section 14 [~~15~~]. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals", revised January 1, 2014 [~~2013~~]; and

(b) "Kentucky Data Coordinator's Manual for Ambulatory Facilities," revised January 1, 2014 [~~2013~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Cabinet for Health and Family Services, 275 East Main Street 4WE, Frankfort, Kentucky 40621[~~40601~~], Monday through Friday, 8 a.m. to 4:30 p.m.

900 KAR 7:030

APPROVED:

Emily Whelan Parento
Executive Director
Office of Health Policy

12/5/13
Date

APPROVED:

Audrey Tayse Haynes
Secretary
Cabinet for Health and Family Services

12/10/13
Date

900 KAR 7:030

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014, at 9:00 a.m. in Auditorium A, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be cancelled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: 502-564-7905, Fax: 502-564-7573

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 900 KAR 7:030
Contact Person: Diona Mullins, (502) 564-9592

1. Provide a brief summary of:

   (a) What this administrative regulation does: This administrative regulation provides clarification and instruction to specified health care providers on the process necessary to submit copies of administrative claims data to the Cabinet.
   (b) The necessity of this administrative regulation: This administrative regulation is necessary so that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data. The administrative regulation contains the updated data submission manuals for hospitals and ambulatory care facilities. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider –Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the 5 separate monthly actual discharge counts for outpatient services.
   (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation is necessary to ensure that health care providers have a uniform mechanism with timeframes and instructions with which to submit the required data to enable the Cabinet to publish the data and reports as required by KRS 216.2925.
   (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation provides detailed instructions to specified health care providers relating to the data elements, forms and timetables necessary to comply with the statute.

2. If this is an amendment to an existing administrative regulation, provide a brief summary of:

   (a) How the amendment will change this existing administrative regulation: This administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider –Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of

the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the 5 separate monthly actual discharge counts for outpatient services.

(b) The necessity of the amendment to this administrative regulation: This amendment is necessary to provide new data submission manuals to facilities to ensure accuracy of the submitted data.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statute by providing a standardized method of reporting by hospitals and ambulatory care facilities.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the statutes as it provides detailed instructions for submission of required data elements.

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation will affect 229 hospitals and ambulatory facilities which submit data to the Cabinet.

4. Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Each entity will collect and submit data as required. Entities are already required to submit data. This administrative regulation incorporates by reference updated data reporting manuals. Revisions to the manuals were necessary due to the addition of one new payor code to identify a new Medicaid MCO provider – Anthem Health Plans of Kentucky. Additionally changes were made to incorporate: 1) the addition of the requirement to report new CPT/HCPCS codes effective 1/1/14; 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the 5 separate monthly actual discharge counts for outpatient services.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Each entity will collect and submit data as required. Entities are already required to submit data. This regulation incorporated by reference

manuals that were revised to provide detailed submission requirements. Therefore, no additional cost will be incurred by entities to comply with this amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Data integrity is improved as all applicable payor codes are now included in the manuals and instructions have been provided related to 1) the addition of the requirement to report new CPT/HCPCS codes, 2) the implementation of ICD-10-CM and ICD-10-PCS effective 10/1/14; and 3) the addition of the requirement in 2014 to report a total inpatient discharge count and total outpatient discharge count instead of the 5 separate monthly actual discharge counts for outpatient services.

5. Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

   (a) Initially: No additional costs will be incurred to implement this administrative regulation. The Office of Health Policy currently collects data and has the necessary data collection system in place.

   (b) On a continuing basis: No additional costs will be incurred.

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The source of funding for the implementation and enforcement of this administrative regulation will be the Office of Health Policy's existing budget. No new funding will be needed to implement the provisions of the amended regulation..

7. Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in fees or funding is necessary.

8. State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does not establish any fees and does not increase any fees either directly or indirectly.

9. TIERING: Is tiering applied? (Explain why or why not)
Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 900 KAR 7:030 Contact Person: Diona Mullins

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This amendment may impact any government owned, controlled or proposed hospitals and ambulatory care facilities.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. The authorizing statutes are KRS 216.2920-216.2929.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? This administrative regulation will not generate any revenue.

   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? This administrative regulation will not generate any revenue.

   (c) How much will it cost to administer this program for the first year? No additional costs will be incurred to implement this administrative regulation.

   (d) How much will it cost to administer this program for subsequent years? No additional costs will be incurred to implement this administrative regulation on a continuing basis.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): None
Expenditures (+/-): None
Other Explanation: None

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Office of Health Policy

900 KAR 7:030. Data reporting by heath care providers.

Summary of Material Incorporated by Reference

1. "Kentucky Inpatient and Outpatient Data Coordinator's Manual for Hospitals", revised January 1, 2014. Changes include:

- **Cover Page** - Revised date changed to January 1, 2014.
- **Table of Contents** - Revised to reflect new page numbers.
- **Page 5 What is Kentucky IPOP?** - Revised language to include all outpatient surgery, all observation care, all emergency department, and SPECT.
- **Page 6 Administrative Regulation 902 KAR 19:010** - Revised language to include ICD-10-CM diagnostic codes (effective 10/1/2014).
- **Page 7 KBSR Applicable Conditions and ICD-9 Codes**- Revised to reference Appendix B for list of ICD-10-CM codes.
- **Page 10 Observation Care –** Revised language to specify Data for Observation Care will be determined based upon Revenue Codes OR Procedure Codes.
    - Data will be determined based upon Revenue Codes OR Procedure Code**s.**

Observation Revenue Codes	**OR**	**Observation Procedure Codes**
0762	**OR**	**99234, 99235, 99236, 99217 – 99220, 99224 – 99226, and G0378 – G0379**

- **Page 10 Emergency Department** – Revised language to specify Data for Emergency Department will be determined based upon Revenue Codes OR Procedure Codes.
    - Data will be determined based upon Revenue Codes OR Procedure Codes.

Emergency Department Revenue Codes	**OR**	**Emergency Department Procedure Codes**
0450-0452 0456 0459 0680-0684	**OR**	**99281 – 99288 and G0380 – G0384**

0689		

- **Page 12 Patient Accounts** – Revised language to include All outpatient surgery, All observation care, All emergency department, SPECT.
- **Page 13 2014 CPT Codes**
  - Changed effective date to 01/01/2014.
  - Outpatient Surgery
    - Collect all Category III Codes.
      - 0019T – 0339T
  - Other Outpatient Procedures – Added new codes.
    - 93582 -93583
- **Page 16 Data Submission Timetable** – Deleted last sentence which stated a date specific schedule will be available on the KY IPOP website.
- **Page 19 Case Count Submission** – Deleted the last sentence of first paragraph "Please see the Discharge Case Count online entry section of this manual for step-by-step instructions on this process."
- **Page 20 Outpatient Counting Method** – Deleted page 20. Only total inpatient and total outpatient cases will be counted.
- **Pages 24-25, 58-59** and **101-102 Payer Mapping Codes**
  - Added New Payer Code 98991 –Blue Cross Blue Shield Medicaid Managed Care.
- **Pages 28, 62, and 113-114 Principal Diagnosis** – Added "or valid ICD-10-CM codes effective 10/1/2014." Add language "Principal ICD-10-CM diagnosis is Z38 as of 10/1/2014."
- **Pages 28 and 62 1st Other Diagnosis** – Under reference charts added language to indicate that as of 10/1/2014 additional External Causes of Morbidity codes can also be mapped to the remaining fields.
- **Pages 114-115 1st Other Diagnosis** – Under reference charts added language "As of 10/1/14 additional External Causes of Morbidity Codes must be reported in the secondary/other diagnosis segment using Qualifier BO or BQ."
- **Pages 30-31 and 115 1st Position Procedure Code**– Added the language "effective 10/1/2014 only ICD-10-PCS accepted for Inpatient."
- **Pages 32-34, 65-67, and 107-111 Patient Discharge Status** – Included the following discharge status codes
  - 69 = Discharge transferred to a designated disaster alternate care
  - 81 = Discharged to Home or Self Care with a Planned Acute Care Hospital IP Readmission
  - 82 = Discharged/Transferred to a Short Term General Hospital for IP Care with a Planned Acute Care Hospital IP Readmission

- 83 = Discharge/Transferred to a SNF with Medicare Certification with a Planned Acute Care Hospital IP Readmission
- 84 = Discharged/Transferred to Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital IP Readmission
- 85 = Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital IP Readmission
- 86 = Discharged/Transferred to Home Under Care of Organized Home Health Organization with Planned Acute Care Hospital IP Readmission
- 87 = Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital IP Readmission
- 88 = Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Hospital IP Readmission
- 89 = Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital IP Readmission
- 90 = Discharged/Transferred to an IRF including Rehabilitation Distinct Part of a Hospital with a Planned Acute Care Hospital IP Readmission
- 91 = = Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital IP Readmission
- 92 = Discharged/Transferred to Nursing Facility Certified by Medicaid but not Certified by Medicare with Planned Acute Care Hosp IP Readmission
- 93 =Discharged/Transferred to Psychiatric Hospital or Psychiatric Distinct Part of a Hospital with a Planned Acute Care Hosp IP Readmission
- 94 = Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital IP Readmission
- 95 = Discharged/Transferred to Another Type of Health Care Institution not Defined in this Code List with a Planned Acute Care Hosp IP Readmission

- **Pages 41, 76, and 104 Patient ID # 4** – Changed language to state Patient Control Number / ID #.
- **Pages 44, 79, and 113- 114 1st E-Code**– Added language "(ICD-9-CM Code) External Causes of Morbidity Code (ICD-10-CM as of 10/1/2014)".
  - Pages 44, 79, and 113 1st E Code – Added language "As of 10/1/2014 ICD-10-CM External Causes of Morbidity codes will be accepted."
- **Pages 113-114 1st E-Code** – Added language "As of 10/1/2014 additional External Causes of Morbidity codes must be reported in the secondary/other diagnosis segment using Qualifier BO or BQ."
- **Pages 45 1st Present on Admission Indicator for 1st E-Code** - Changed language to "As of 10/1/2014 Present on Admission Indicator for 1st External Cause of Morbidity Code".

- **Page 112 Present on Admission** – Added language "As of 10/1/2014 POA indicator for the ICD-10-CM External Causes of Morbidity."
- **Pages 45, 79, and 114-115 2nd E-Code** -Changed language to "(ICD-9-CM code) External Causes of Morbidity Code (ICD-10-CM as of 10/1/2014)."
- **Pages 45 2nd Present on Admission Indicator for 2nd E-Code** - Changed language to "As of 10/1/2014t Present on Admission Indicator for 1st External Causes of Morbidity Code".
- **Pages 45, 79, and 114-115 3rd E-Code**– Added language "(ICD-9-CM code) External Causes of Morbidity Code (ICD-10-CM) as 10/1/2014)."
- **Page 45 3rd Present on Admission Indicator for 3rd E**-Code- Added language "As of 10/1/2014 Present on Admission Indicator for 1st External Cause of Morbidity Code".
- **Pages 51 and 118 Operating Clinician ID Number / NPI**– Changed language to "Required for inpatient if the record qualifies as a surgical record."
- **Pages 53 and 113 Admitting Diagnosis** – Changed language to state must be valid ICD-10-CM diagnosis code as of 10/1/2014 to describe the patient's diagnosis at time of inpatient admission.
- **Pages 41, 77, and 112 ICD Diagnosis Code Version Qualifier** – Changed to "ICD-10 Version effective 10/1/2014."
- **Page 87 Operating Clinician ID Number / NPI**– Changed language to "Required for any outpatient record if there is a surgical CPT/HCPCS code present on the record." Referenced the table of CPT/HCPCS codes on page 15.
- **Page 90 and 113 1st "Patient's Reason for Visit" Diagnosis Code** – Added language "or as of October 1, 2014 a valid ICD-10-CM diagnosis code".
- **Page 119 Admitting (1st Other) Clinician ID # / NPI** – Add qualifier ZZ to reference chart.
- **Page 125-139 Record Edits** - Revised language in edits to include ICD-10-CM as of 10/1/2014.

Total number of pages -168

2. "Kentucky Data Coordinator's Manual for Ambulatory Facilities", revised January 1, 2014. Changes include:

- **Cover Page** - Revised date to January 1, 2014
- **Table of Contents** – Revised to reflect new page numbers.
- **Page 4 What is Kentucky IPOP?**- Section was revised to state that patient accounts should include all outpatient surgery, all observation care, all emergency department and SPECT.

- **Page 7 Mandatory Data Submission** - Revised language to state all outpatient surgery, all observation care, all emergency department and SPECT are required to be submitted to IPOP.
- **Page 8 Outpatient Surgical, Mammography and Other Outpatient Procedure** - Revised language to state all outpatient surgery, all observation care, all emergency department and SPECT.
- **Page 9 2013 CPT Codes**
    - Changed effective date to 01/01/2014.
        - Collect all Category III Codes.
            - 0019T – 0339T
    - Other Outpatient Procedures – Added new codes.
            - 93582 – 93583
- **Page 10 Data Submission Timetable** – Deleted last sentence "A date specific schedule will be available on the KY IPOP website."
- **Page 13 Case Count Submission** – Deleted second sentence " Please see the Discharge Case Count Online Entry section of this manual for step-by-step instructions on this process."
- **Page 13 Case Count Submission** – Deleted the following columns from table: outpatient surgical reported counts, observation care reported counts, emergency department reported counts, mammography reported counts, other procedures reported counts. Change column headed "Total Outpatient Reported Counts" to "Outpatient Reported Counts".
- **Page 14 Outpatient Counting Method** – Deleted page 14. Only total inpatient and total outpatient case should be counted.
- **Pages 19, and 41- 42 Payer Mapping Co**des – Added 98991-BCBS Medicaid Managed Care.
- **Page 20 Principal Diagnosis – Added "**As of 10/1/2014 must be a valid ICD-10-CM code established after admission as responsible for outpatient care necessity."
- **Page 45 Principal Diagnosis- Added "**As of 10/1/2014 must be a valid ICD-10-CM code established after admission as the primary reason for outpatient care necessity."
- **Pages 27 and 44 Patient ID # -** Revised language "Patient Control Number / ID #".

Total number of pages- 74